STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

CAPTA[1] REPORT

In the Matter of
Demetrius Labell
Minor Child[2]

9-03-2006-00001

January 22, 2010

[1] The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 31 Del.C. § 323 (a).
[2] To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission ("CDNDSC") was statutorily created in 1995 after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The mission of CDNDSC is to safeguard the health and safety of all Delaware children as set forth in 31 Del.C., Ch., 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child's death or near death and determine whether system recommendations are necessary to prevent future deaths or near deaths. The process brings professionals and experts from a variety of disciplines together to conduct in-depth case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary of Incident

The case regarding Demetrius Labell was reviewed by the Child Abuse and Neglect Panel as a child death in 2005. The child died at two years, five months of age due to cardiac arrest resulting from blunt force trauma to the abdomen. Until the time of the child's death, he was under the supervision and care of his mother. However, at the time of alleged incident, the child was under the direct supervision of his paternal uncle.

During the investigation by the Division of Family Services ("Division") the child's mother reported that she had left the child in the care of his paternal uncle for approximately three hours on the day of the alleged incident. When the mother returned home she found the child sleeping and the paternal uncle informed the mother that the child had twice fallen off his skateboard while playing in the basement. The paternal uncle stated that when the child first fell he hit his head but continued to play. At the second fall, the child hit the opposite side of his head. At this point in time, the child began to cry but his injuries did not appear to be serious.

The child's mother, initially, claimed that the child was under her supervision at the time of the alleged incident. She later admitted to lying because she was aware that the child's paternal uncle had warrants out for his arrest and she was trying to circumvent his apprehension. (The child's paternal uncle had a criminal history consisting of possession of a non narcotic/controlled substance, possession of drug paraphernalia, possession of a deadly weapon by a person prohibited, offensive touching, resisting arrest, endangering the welfare of a child, and reckless endangering in the second degree. Even with this history, the child's mother still considered the paternal uncle to be an appropriate caregiver.)

According to the police investigation, the child was reported to have fallen two times while skateboarding in the basement, five days prior to his death. At some point the mother called the child's physician's office. The physician's office did not document the date or time the mother contacted the child's pediatrician reporting the child to be vomiting, pale, not wanting to eat or drink, and having decreased urine output. Once the physician's office was contacted the mother was instructed by the office to take the child

to the hospital immediately. While seeking transportation to the hospital, the mother observed the child to be limp and unresponsive. The mother called 911 and began CPR. When emergency services arrived at the child's home, the child was observed to be in respiratory distress. The child was transported to the hospital via ambulance and pronounced dead shortly after arrival by the attending physician.

Upon the child's death an autopsy was performed by the Medical Examiner's Office which revealed that the child was found to have nineteen separate bruises on his face and body. These bruises were not consistent with the history given by the mother and paternal uncle. Additionally, the child had no defensive wounds, such as scrapes, which would be expected if the child tried to brace or guard himself from falling off a skateboard. Furthermore, the autopsy found that the child received a blunt force blow to the abdomen, but neither the mother nor the paternal uncle admitted to striking the child. The blow to the abdomen caused a rupture in the child's small intestine resulting in sepsis which eventually led to child's death.

Eleven days after the child's death, the Division received a hotline report alleging the physical abuse of Demetrius Labell. The report was made by the investigating police agency after concern about the safety of the child's younger sibling was raised by authorities.

In reviewing the case, it was also noted that the Division had received a hotline report alleging physical abuse of this child by the mother 6 weeks prior to the child's death. The call was placed by a DFS caseworker who had witnessed verbally aggressive behavior by the mother toward the child, then the mother hitting the child twice, possibly with an open hand, but caller did not see clearly. The caller reported second-hand information that the mother then hit the child with closed-hand at another point. DFS indicated the hotline report was rejected because it did not meet DFS maltreatment "definition" and therefore no investigation was completed.

As a result of the child's death, the child's mother and paternal uncle were both charged with Murder by Abuse or Neglect in the first degree, a felony offense. After the alleged incident, the child had made numerous complaints of his stomach hurting and both the mother and paternal uncle failed to seek the necessary medical attention that the child required. The child's mother admitted that she failed to obtain medical attention, in a timely manner, which ultimately contributed to her son's death. However, the mother denies that she caused the fatal blow to her son's abdomen. In 2007, with respect to Demetrius' death, the mother pled guilty to Endangering the Welfare of a Child, a felony offense. The mother was sentenced to one year and two months in prison. In addition, the paternal uncle pled guilty to Assault in the second degree, a felony offense. The paternal uncle was sentenced to two years and seven months in prison for the injuries to Demetrius.

System Recommendations

The following recommendations were put forth by the Commission:

(1) The Division of Family Services must ensure that employees are strictly following all policies and procedures during the hotline intake process, with particular attention to all risk factors, including the status of the reporter, with

greater credibility assigned to professionals. CDNDSC notes that this recommendation has been made on five previous occasions by this Commission and other review bodies.

a. *Rationale:* If the hotline report had been accepted 6 weeks prior to the death and an investigation begun, then the risk of further abuse of the child may have been better scrutinized by DSCYF. The hotline did not comply with policy when a WIC caseworker made the report.
b. *Anticipated Result:* An increased protection of at risk children by relying on trained professionals as well as factors such as DFS history, age of a child, and caregiver's emotional state to guide the hotline intake process.
c. *Responsible Agency*: DSCYF

(2) The Division of Family Services should establish a quality assurance process for reviewing rejected hotline reports given the repeated failures to adhere to established policies in this and other cases and the volume of reports that are rejected.

a. *Rationale:* If the rejected hotline reports were reviewed, failure to adhere to established policies could be remedied in a timely manner instead of reviewed after an incident occurs that bring it to light.
b. *Anticipated Result:* To increase the protection of potentially at risk children in Delaware by ensuring accurate screenings and risk assessments of the hotline.
c. *Responsible Agency:* CDNDSC/CPAC Risk Assessment Subcommittee

(3) CDNDSC supports the legislation to amend Title 16 of the Delaware Code relating to the penalties for failing to report suspected child abuse and/or neglect. This legislation converts the criminal action for failure to comply with the mandatory reporting of suspected child abuse into a civil action with financial penalties. Whomever violates §903 of this Title shall be liable for a civil penalty not to exceed $5,000 for the first violation, and not to exceed $50,000 for any subsequent
a. *Rationale:* A Delaware citizen who lived in the house with the mother and the child was aware of the physical abuse perpetrated by the mother and did not report it.
b. *Anticipated Result:* to ensure that Delaware's statutes are adequately protecting children and holding all citizens responsible to protect Delaware's children through appropriate public education.
c. *Responsible Agency:* CDNDSC and CPAC.

(4) All medical documentation, including patient phone calls for advice, should be immediately time and date stamped by every medical practice. This case will be referred to the Medical Review Board in order to assess whether or not the pediatrician's office was in compliance with the standard of care.

a. *Rationale:* The pediatrician's office record of the mother's call regarding the child's condition was not consistent date or time-wise with the timing of Demetrius' injuries. If the mother had called the day before the date of death and did not follow the physician's instructions to take the child immediately to the Emergency Room, then great concerns exist regarding medical follow-up of apparently urgently ill patients. However, if the mother called on the date of death and did follow physician instructions, the only concern remains date and time documentation.
b. *Anticipated Result:* To ensure an accurate reflection of patient/practice contacts in the medical record and establish proper follow-up with urgently ill patients.
c. *Responsible Agency:* CDNDSC shall send a letter to the physician's office involved to encourage compliance with the necessity of appropriate and timely medical documentation, especially date and time recording of phone conversations and encouraging follow-up of patients sent to Emergency Rooms urgently.

(5) The Division of Family Services shall provide clarification of the maltreatment "definition" per DFS policy for caseworkers who are responsible for hotline intakes. These frontline responders should also give higher deference to professional who are reporting.

a. *Rationale:* If the hotline report had been accepted 6 weeks prior to the death and an investigation begun, then the risk of further abuse of the child may have been better scrutinized by DSCYF. The hotline did not comply with policy when a WIC caseworker made the report.
b. *Anticipated Result:* An increased protection of at risk children by relying on trained professionals as well as factors such as DFS history, age of a child, and caregiver's emotional state to guide the hotline intake process.
c. *Responsible Agency*: DSCYF